

# Kickoff Meeting for 2016 Health Benefit Plan Reporting In Maryland

**December 2, 2015  
11:00am – 1:00pm (EST)**

**Theressa Lee, Director  
Center for Quality Measurement and Reporting**



# Agenda

- QPRR Highlights
- HEDIS Audit Process
- CAHPS Survey Process
- RELICC Assessment Process
- RELICC-MLDF
- BHA
- QP

# HEDIS 2016

Presenter: Paul Mertel

**MHCC Project Partner:**

HealthcareData Company, LLC  
600 Bent Creek Boulevard, Suite 160  
Mechanicsburg, PA 17050  
717-458-0554  
[www.hdcdata.com](http://www.hdcdata.com)



# Reporting and Audit Activities

HEDIS 2016



# Overview

- New Fraud and Misconduct Hotline
- QPRR Requirements
- Specification Changes
- Audit and Reporting Timeline
- CAHPS and IDSS Changes
- New Audit Requirements for 2016



# HEDIS 2016 - Fraud and Misconduct Hotline

NCQA does not tolerate submission of fraudulent, misleading or improper information by organizations as part of their survey process or for any NCQA program.

NCQA has created a confidential and anonymous Reporting Hotline to provide a secure method for reporting perceived fraud or misconduct, including submission of falsified documents or fraudulent information to NCQA that could affect NCQA-related operations (including, but not limited to, the survey process, the HEDIS measures and determination of NCQA status and level).

## **How to Report**

### **Toll-Free Telephone:**

English-speaking USA and Canada: **855-840-0070** (not available from Mexico)

Spanish-speaking North America: **800-216-1288**

Mexico: user must dial **001-800-216-1288**

**Web Site:** <https://www.lighthouse-services.com/ncqa>

**E-Mail:** [reports@lighthouse-services.com](mailto:reports@lighthouse-services.com) (must include NCQA's name with the report)

**Fax:** 215-689-3885 (must include NCQA's name with the report)



# MHCC Required Measures

HEDIS 2016



# HEDIS 2016 Reporting Requirements

- Refer to QPRR published on December 1, 2015
- Removed ASM measure from draft QPRR
- Retained January 31, 2016 as the new date for submission of Quality Profile
- Behavioral Health Assessment Tool and Quality Profile template published on Sharefile and available for download with other administrative instructions
- Instructions for Member Level File in QPRR



# Audit and Reporting Timeline

HEDIS 2016



# HEDIS 2016 – Early Key Dates

- HOQ opens on January 11, 2016. Must be completed by February 29, 2016. Be sure to enter any QHP submissions under Org ID.
- Refer to Audit Information Packet for instructions on submission requirements for CAHPS. WBA Research will cover more particulars in their presentation.
- Plans must select Adult Survey for accreditation scoring
- Roadmaps due by January 29, 2016
- Data entry into nonstandard and member reported databases must stop on March 1, 2016
- Approval for ALL databases (including standard) must occur by March 31, 2016. Approval can start as early as December 1, 2015 but no additional entries are allowed once database is submitted for approval.



# HEDIS 2016 – Timeline (complete timeline in Volume 2)

HEDIS Activity	Due
Organization completes the medical record abstraction process for all measures and sends final numerator-compliant counts for all measures and exclusions for MRRV. (HDC – complete Hybrid Input File Form)	May 16
Auditor picks measures from the measure groups and exclusions. Sixteen records are selected from each for MRRV review. Auditor informs plan of the selections.	May 20
Organization sends selected records to the auditor for validation	May 27
Auditor begins communicating MRRV results, including MRRV corrective actions, with the organization	June 1
Organization completes all corrective actions and follow-up requests and sends the plan-locked commercial Medicaid and Medicare submissions to the auditor. Submits patient level file for all products – includes new patient level file for Commercial and Medicaid submissions.	June 8
Auditor performs final rate review and ensures that the MRR numerator counts entered in the IDSS match the lists submitted in May. Reconciles patient level file with IDSS totals.	June 15
Organization submits the auditor-locked commercial, Medicaid and Medicare IDSS submission with attestation to NCQA	June 15
Organization submits patient-level data for Medicare products only	June 15
Licensed Organization submits commercial, Medicaid and Medicare Final Audit Reports to NCQA	July 15



# Specification Changes

HEDIS 2016



# Notable Measure Changes

## **ABA**

- Members younger than 21 on the date of services must have BMI percentile rather than BMI value (HEDIS 2015 was 19 or younger)
- Could impact supplemental databases already created

## **WCC**

- BMI values for members 16-17 is no longer acceptable. Must be BMI percentile
- Added an end note that notation of anticipatory guidance related solely to safety (e.g. member wears helmet or water safety) without specific mention of physical activity recommendation does not count
- Could impact supplemental databases already created



# Notable Measure Changes

## CIS

- Added note that 14-day rule does not apply to MMR
- Added new value set to identify Hepatitis B vaccines administered at birth. One of the 3 Hep B vaccines can be given on date of birth + 7 days
  - ICD10 code or ICD9 99.55
- Expected impact – slightly increased rates for MMR, increased rates for all combo measure

## BCS

- Added new value sets to identify bilateral mastectomies (All ICD10 codes)
- Expected impact – minor increase in BCS exclusions



# Notable Measure Changes

## CCS

- Added hybrid examples vaginal pap smear in conjunction with hysterectomy and documentation of hysterectomy and state that patient no longer needs pap/cervical cancer screening
- Expected impact – minor increase in number of exclusions

## CBP

- Clarified the diabetes flag assignment
- Clarified that if hypertension diagnosis is not confirmed, the member is excluded and replace by a member in the oversample
- Expected impact – depends on the plan. Some plans already followed this; some did not.



# Notable Measure Changes

## **CDC**

- Revised the requirements for urine protein test for nephropathy. A screening test meets criteria, whether or not the result is positive or negative.
- Clarified that optional exclusions should be applied only with the member is numerator negative for at least one CDC indicator – except poor control. i.e. leave fully compliant diabetics in the CDC measure

## **PPC and FPC**

- Deleted the use of infant claims to identify deliveries

## **IPU, IAD, MPT**

- Added specific value sets for identifying acute stays (identify all stays and subtract nonacute stays)



# CAHPS and IDSS Changes

HEDIS 2016



# Changes in CAHPS Survey

- Systematic Sampling vs. Random Sample
- Plans no longer allowed to remove dis-enrollees after audit of the sample frame
- NCQA will perform additional validation checks
  - Compare with plan's prior year's results
  - Compare with national results (prior year and current year)
  - Conduct primary source verification
    - Ask for copies of returned surveys and compare with data file
    - Review telephone interviews and compare with results in data file



# Changes in IDSS – Proposed (not final)

## Audit Review Table Design

- Remove the *Report Measure*, *Benefit Offered* and *Rotated Measure* columns
- Add *Audit Designation* column
- Measures not reported, biased, or no benefit must be identified by auditor comments in Audit Review Table
- *Comment* field will be default based on uploaded data
- NA designations will now show a rate

Third Tier Validation Added: will check for outlier limits on all measures (e.g., ABA rate not exceed 100%)



# Audit Designations in IDSS – HEDIS 2016

Rate/Results	Audit Designation Description
<b>R</b>	<b>Reportable.</b> A reportable rate was submitted for the measure
<b>NA</b>	<b>Small Denominator.</b> The organization followed the specifications but the denominator was too small (<30) to report a valid rate
<b>NB</b>	<b>No Benefit.</b> The organization did not offer the health benefit required by the measure (e.g. mental health)
<b>NR</b>	<b>Not Reported.</b> The organization chose not to report the measure
<b>NQ</b>	<b>Not Required.</b> The organization was not required to report the measure
<b>BR</b>	<b>Biased Rate.</b> The calculated rate was materially biased
<b>UN</b>	<b>Un-Audited.</b> The organization chose to report a measure that is not required to be audited. This result applies only to a limited set of measures (e.g. Measures Collected Using Electronic Clinical Data Systems).



# New Audit Requirements

HEDIS 2016



# HEDIS 2016 – New Audit Requirements

## Major Changes in Audit Processes

- Roadmap submitted by January 31, 2016 (no change from HEDIS 2015)
- Attestation submitted/dated when Roadmap is designated complete
- Separate Section 5 submitted **for each** supplemental data source
- Plan submits consolidated numerator totals for all MRR hybrid measures by May 16, 2016 – use HDC’s Hybrid Input File form completed by plan
- Auditor notifies plan of selected measures and plan sends member level lists back to HDC
- HDC sends random sample by May 20, 2016
- Impact of supplemental data report submitted to auditor
- IDSS plan locked by June 8, 2015 – no major changes allowed after locked
- Tier 3 Validation now performed – must sign off on warnings (Tier 2 and 3)



# HEDIS 2016 – New Audit Requirements

## Major Changes in Audit Processes

### **Member/Patient Level Detail File**

- Required now for all Commercial and Medicaid submissions
- One row in file for every member in HEDIS report
- File totals are reconciled, by measure, with to IDSS totals
- Similar to PLD file required by CMS for Medicare submissions
- File will be provided from certified software (file layout pending)
- Impact on plans?
  - MLDF and IDSS must match 100%
  - Auditor allowed to give 1% variance in totals this first year
  - Reduces the time for any comparisons and validations
  - No longer any opportunity to make last minute changes in IDSS



# CAHPS<sup>®</sup>

## Consumer Assessment of Healthcare Providers and Systems

Presenter: Renee Henley

**MHCC Project Partner:**

WBA Research  
2191 Defense Highway, Suite 401  
Crofton, MD 21114  
410.721.0500  
[www.WBAresearch.com](http://www.WBAresearch.com)

# CAHPS® - Summary of Changes for 2016

- NCQA revised the telephone phase by limiting the telephone attempts to six
- “Complete and Valid Survey” definition has been revised
  - Responses indicate that member meets eligible criteria
  - 3 of the 5 questions listed below are answered correctly

Survey Type	Questions for Complete & Valid Survey				
Adult Commercial	Q3	Q15	Q24	Q28	Q42

- Added disposition codes (M31 or T31 Non-response, incomplete)

# CAHPS® - Summary of Changes for 2016

- NCQA revised sampling methodology
  - Systematic sampling method (instead of a random sample)
- No restrictions on oversampling rates
  - 5% increments and prior approval not required
- Disenrolled members may not be removed from the sample
- De-duplicating sample frames across Survey Vendors requires NCQA approval

# Summary of CAHPS® 2016

- CAHPS® 5.0H Adult - Commercial Survey
- Global Ratings Questions include:
  - All Health Care
  - Personal Doctor
  - Specialist Seen Most Often
  - Health Plan
- Composite Scores include:
  - Claims Processing
  - Customer Service
  - Getting Care Quickly
  - Getting Needed Care
  - How Well Doctors Communicate
  - Shared Decision Making
  - Plan Information on Costs
- Item-Specific Question Summary Rates include:
  - Health Promotion and Education
  - Coordination of Care

# CAHPS<sup>®</sup> Sample Size

➤ Sample Size:

	<b>Adult</b>
Required Sample Size	1,100
Oversampling Rate	10%
Final Sample Size	1,210

- At the Plan's cost, each Plan has the option to increase the over-sampling rate in addition to the 10% executed by MHCC

# CAHPS® Process 2016

- Complete CAHPS® Data Collection Form
  - Return to HDC early January 2016
- HOQ to be released on January 11<sup>th</sup>
  - List your auditor and HDC as audit firm
  - List CAHPS survey being conducted (Adult Commercial for MHCC)
  - Notify HDC when completed
  - Submit full sample frame to HDC
  - HDC will record reportability of surveys after validation
- HDC will issue email of approval and send to Plan
- Plan forwards email and securely zipped and encrypted sample frame to WBA Research no later than January 22<sup>nd</sup>
- Mark HOQ final after all information is entered

# Key Dates - CAHPS® 2016

Action	Completion
If desired, Plans forward supplemental questions to WBA Research	December 4 <sup>th</sup>
WBA Research receives MHCC logo, signature for mailing pieces, letterhead, etc.	December 15 <sup>th</sup>
Plans send written notification to WBA Research regarding additional over-sample	December 20 <sup>th</sup>
Plans submit CAHPS® Data Collection Form to HDC	Early January
WBA Research submits survey materials to MHCC and NCQA for approval	Early-Mid January
Start HOQ completion for CAHPS® Sample Frame (add any new HEDIS® auditor)	January 11 <sup>th</sup>
HDC completes review, validates HOQ, and notifies Plan via email	January 22 <sup>nd</sup>
Plans send audited sample frame files that are securely zipped and encrypted to WBA Research (with forwarded email from HDC)	January 22 <sup>nd</sup>

# Key Dates - CAHPS® 2016

Action	Completion
WBA Research mails 1 <sup>st</sup> questionnaire with cover letter	Week of February 29 <sup>th</sup>
WBA Research mails 1 <sup>st</sup> reminder postcard	Week of March 7 <sup>th</sup>
WBA Research processes returned mail	Ongoing
WBA Research mails 2 <sup>nd</sup> questionnaire with cover letter	Week of April 4 <sup>th</sup>
WBA Research mails 2 <sup>nd</sup> reminder postcard	Week of April 11 <sup>th</sup>
WBA Research appends telephone numbers of sample files	Week of April 18 <sup>th</sup>
WBA Research conducts Computer Assisted Telephone Interviews (CATI)	April 25 <sup>th</sup> - May 15 <sup>th</sup>
WBA Research will process member-level data files and submit to NCQA	May 16 <sup>th</sup> - 27 <sup>th</sup>
NCQA makes survey results, validated member-level data files and summary-level data files available	May 31 <sup>st</sup>
Plans review survey results from NCQA and submits signed Attestation of Accuracy	By June 15 <sup>th</sup>
WBA Research conducts final analysis and issues report	August

# RELICC

## Race/Ethnicity, Language, Interpreters, and Cultural Competency

Presenter: John Miller

**MHCC Project Partner:**

MidAtlantic Business Group on Health  
PO Box 0866 Greenbelt, MD 20768

301.552.4237  
[www.mabgh.org](http://www.mabgh.org)

# Background – Maryland RELICC Assessment

- Maryland RELICC (race/ethnicity, language, interpreters, and cultural competency) Assessment:
  - A custom designed quality and performance assessment tool for use by the State of Maryland which focuses on addressing disparities issues
  - Customized by the MidAtlantic Business Group on Health (MABGH), with support from the National Business Coalition on Health (NBCH)
  - Based primarily on related questions from the leading, national, evidence-based RFI tool, eValue8™
  - All of the carriers in Maryland have previously participated in eValue8 in some region
  - MHCC sought feedback from key stakeholders, including Maryland's health benefit plans, in the design and implementation of the RELICC Assessment

# Basis – Maryland RELICC Assessment

- Purchaser voice/Evidence-based
  - RELICC integrates a combination of purchaser expectations and evidence-based performance measures that have been demonstrated to drive improvements and increase the overall value for purchasers and consumers
- Expert contributors
  - Questions developed in partnership with purchasers, plans and other leaders in value-based purchasing: Catalyst for Payment Reform (CPR), Pharmacy Quality Alliance, and Health Care Incentives Improvement Institute (HCI3)
  - The National Committee on Quality Assurance (NCQA), the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC) and other federal, state and academic centers have provided assistance
  - Every effort made to align with the programs/perspective of these entities
- Advisory councils
  - Business/health coalitions, individual purchasers, and health benefit plans comment and advise on questions

# RELICC Requirement

- The 2015 Quality and Performance Reporting Requirements (QPRR)
  - Requires health benefit plans participating in the Health Benefit Plan Quality and Performance Evaluation System to utilize the RELICC tool for enhanced reporting to MHCC
  - With a successful 2013 pilot, RELICC information reported this year is scheduled for public release in the 2015 Health Benefit Plan Quality and Performance Report

# RELICC Description

- 2015 Maryland RELICC Assessment consists of:
  - 8 Administrative Questions
    - Health benefit plan product information
    - Contact and organization information including tax status
    - Enrollment information (Maryland membership in each of the products)
  - 13 RELICC-related Questions
    - 9 questions on racial, cultural and language competency
    - 4 questions on racial, cultural and language use
  - Plus an opportunity for plans to provide additional information on how the plan ensures that culturally competent health care is provided
  - As well as an Attestation of Accuracy that is signed by the designated health benefit plan representative
- Future years of the Maryland RELICC Assessment may include an expansion that incorporates additional components of the eValue8 RFI that are of importance to Maryland

# RELICC Notes

- Auto-populate
  - Plans who have responded previously to eValue8™ and/or RELICC have the ability to select as a “default” their prior response or the scored response
- HMO/PPO in same template
  - The PPO question always follows the HMO question. Plans providing responses for both HMO and PPO product lines should select both the HMO and PPO boxes in 1.1.5 to activate the questions

# RELICC Administration

- Access and support
  - NBCH process and directions documents including mapping document and scoring guide
  - ProposalTech technical support with online training
  - Additional Q&A through ProposalTech secure platform and during teleconferences
- Submission should reflect Maryland reporting entities
  - Regional answers should be Maryland specific

# Key Dates – Maryland RELICC Assessment

Action	Completion
RELICC Guidelines document distributed to plans prior to Kickoff Meeting	December 2015
ProposalTech Training Upon Request	Early-Mid-Dec 2015
Kickoff Meeting	Dec 2, 2015
RELICC Release	Dec 7 2015
Questions to ProposalTech Submitted in Writing	Dec 7 - Mar 4, 2016
RELICC Response Due with signed Attestation of Accuracy	Mar 18, 2016
Evaluation and Scoring of Responses (Plans may receive follow up questions)	Mar 21 - Mid-Apr, 2016
Plan response to follow up	Apr 27, 2016
Administrative Reports (preliminary reports issued from contractor to MHCC)	May 13-Early Jun, 2016
Site Visits (or web-based conference option)	Mid-Jun 2016

# Contact Information for RELICC Users

- ProposalTech
  - [truth@proposaltech.com](mailto:truth@proposaltech.com)
  
- National Business Coalition on Health (NBCH)
  - Foong-Khwan Siew: [fsiew@nbch.org](mailto:fsiew@nbch.org)

# BHA and QP



# BHA Highlights

- Continue same queries as prior year
  - Provide the percentage of enrolled Maryland members that have behavioral health benefits with your health benefit plan...
  - ...plus that are served by an external provider/MBHO
  - Provide updated accreditation information for any segment of your health benefit plan directly responsible for behavioral health services that has received accreditation (Name, Accreditation Status, and Date of Accreditation Expiration)
  - Provide Name, Accreditation Status, and Date of Accreditation Expiration for any external entity that provides behavioral health services to health benefit plan members through a contractual arrangement with your health benefit plan
  - Provide accreditation information as of April 2016



# BHA Highlights (continued)

- Additional information needed for this year
  - For each health care discipline including behavioral health, provide the number of network providers located in Maryland and in the plan's overall service area (Psychiatry, Psychology, Social Work, Nurse Psychotherapists, Certified Professional Counselors, and Licensed Clinical Alcohol and Drug Counselors, plus corresponding to the BCR measure, family medicine, internal medicine, OB/GYN physicians, Pediatricians, Geriatricians, and other physician specialists)
  - Provide the percentage of network physicians including Psychiatrists, plus corresponding to the BCR measure, family medicine, internal medicine, OB/GYN physicians, Pediatricians, Geriatricians, and other physician specialists, located in Maryland and in the Plan's overall service area, who are Board Certified
  - Signed Attestation



# QP Highlights

- Theme: Understanding and Addressing Disparities – Focus on Network Adequacy and Accurate Provider Network Information
  - 2-3 page narrative
  - QA/QI initiatives
- Product Summary Table
  - Legal Entity Name
  - Product Name
  - Market Type
  - Number of Enrollees
  - Annual Premium Volume
  - Delivery System \*specify other
  - Tax Status and Ownership
- Signed Attestation



# Key Dates

Action	Completion
Maryland Health Plan Quality Profile Due to HDC (2-3 page narrative and a Product Summary Table)	January 31, 2016
Plan Behavioral Health code, if used, due to HDC (earlier is okay)	March 31, 2016
Maryland Plan Behavioral Health Assessment Due to HDC (report and provider detail file)	April 15, 2016
RELICC member level detail files submitted to HDC	July 1, 2016



How to use this guide

Links and Resources

Need health insurance?

Need to file a complaint?

Technical Information

Who we are / Contact us

## Health Benefit Plans

# Thank You!

It is important to make sure quality health care is available for everyone. One way to make sure that quality health care is available in Maryland is to look at how health benefit plans are performing. There are many types of health benefit plans. One is called the health maintenance organization (HMO) plan. Another is called a point of service (POS) plan. There also is the preferred provider organization (PPO) plan and an exclusive provider organization (EPO) plan. A [Comprehensive Quality Report](#) is put out each year that looks at these plans. There is a "[Consumer Edition](#)" of the Comprehensive Quality Report. It helps you select a health benefit plan. In this report you also will see how health benefit plans are evaluated and reviewed.

To learn more about how consumers rate their health benefit plans, click on Consumer Ratings.

Select one of the topics below

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### GOOD OVERALL RATING OF HEALTH BENEFIT PLAN – 8, 9, OR 10, OUT OF 10

